Washington State Department of Labor & Industries

**January 28, 2016 Industrial Insurance Medical Advisory Committee Meeting**

# Draft Minutes (*actions taken)

| Topic | Discussion & Outcome(s) |
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| **Members present:** Drs. Chamblin, Friedman, Gutke, Harmon, Howe, Lang, Leveque, Seaman, Thielke, Haines, Carter & Waring both on phone<br>**Members absent:** Drs. Tauben (Zoltani – no longer on committee)<br>**L&I staff present:** Gary Franklin, Leah Hole-Marshall, Carly Eckert, Nicholas Reul, Hal Stockbridge, Simone Javaher, Angela Jones, Ian Zhao, Zach Gray, Jena Williams<br>**Public**: Shari Fowler, Regine Neiders | |
| Welcome, Introductions, Minutes, Announcements | Dr. Chamblin welcomed Angela Jones BSN, RN as the new ONC for L&I organizing the IIMAC meetings and writing the guidelines, Jena Williams, Medical Program Specialist (ACHIEV), and Christy Pham, Pharm D<br>Safety Tip provided regarding protection during lightning storm<br>*The minutes from 10/22/2015 were read and approved unanimously. |
| Advisory Committee on Healthcare Innovation and Evaluation (ACHIEV) | Leah Hole-Marshall updated the committee on the morning's ACHIEV meeting. ACHIEV focused on three of the "clusters" in Healthy Worker 2020 (HW2020). Presentations and minutes available at: http://www.lni.wa.gov/ClaimsIns/Providers/ProjResearchComm/PNAG/default.asp<br>• Cluster #1: Core Occupational Care best practice – the focus was on understanding access and capacity needs of the "new" workforce that will be needed to practice in a collaborative, accountable system. The Medical Provider Network is important for removal of a small number of providers, but does not set the standard for best practices. The MPN "access" measures of counting approved providers are important but not sufficient to achieve success in HW2020. Current data sources on panel sizes; types of providers; other insurance access standards; L&I "heat map" data was presented to begin the discussion.<br>• Cluster #2: Surgical best practices: L&I has three major areas that will need to be integrated for a comprehensive surgical best practice cluster: Ortho-Neuro program – a currently existing program incentivizing 6 best practices for surgeons; surgical best practices – a three site pilot that includes best practices and care coordination; and a new purchasing method not yet deployed, based on the Bree Collaborative, that includes both warrantee and bundles for certain surgeries including knee/hip replacement, and for lumbar fusion. ACHIEV members provided feedback about how L&I would integrate those programs.<br>• Cluster #3: Catastrophic care- 5 point plan was reviewed with progress in each.<br>• Top Tier update: L&I incorporated the feedback from the previous meeting and is moving forward with an approach that will allow providers to reach top tier using several pathways – one is through being a COHE high adopter and demonstrating certain best practices; another approach is through an application to top tier where equivalent high adoption of best practices occurs. These routes are primarily for primary care. More routes could be added for specialty, such as high adoption in the new combined surgical best practice program. L&I also confirmed that demonstration of an ability to work within a system and have care coordination is central to any top tier qualification and that the willingness to take complex claims is important but not a requirement. |

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| Bio-psycho-social practice resource<br>Now called: Psychosocial Determinants Influencing Recovery (PDIR) | On behalf of the joint IIMAC and Industrial Insurance Chiropractic Advisory Committee (IICAC) project, Dr. Stephen Thielke presented an update on Psychosocial Determinants Influencing Recovery (PDIR). It is designed to look at better ways of managing psychosocial risk factors, as opposed to diagnosing and separately managing psychiatric disease and illness in more traditional ways, which have not proven beneficial. He presented 3 screening algorithms developed so far. Asking, "What are your expectations for recovery?" is an example of a question that may lead to further stepped care management.<br>Multiple questions were asked from the committee members about access to mental health services within the L&I system. Lack of access to mental health professionals is a current barrier; and lack of training about managing mental health and psychosocial issues were mentioned as obstacles. L&I is discussing a plan to help implement techniques like motivational interviewing, and incentivizing a collaborative care model for chronic pain and behavioral health. Members offered suggestions including early behavior intervention in the workplace, workplace advocacy programs, promoting community mental health workers, and training for doctors in motivational interviewing techniques with structured language. |
| Knee guideline and subcommittee | Dr. Chris Howe, Chair of the knee surgery subcommittee, gave an update on the progress of the guideline. An ambitious time line was presented- the subcommittee will bring a final draft to IIMAC in April. A new uniform and systematic format for the narrative section was presented with an example from the total knee arthroplasty section.<br>Some discussion of the impact of BMI in the knee criteria-a BMI greater that 40 indicates worse outcomes, and an example was presented as to how this was integrated into the criteria table. Comments were offered about obesity being a frequent barrier to recovery due to problems with rehab methods such as exercise.<br>The status of viscosupplementation was raised; there is a HTCC decision that all but prohibits use–a link to this coverage decision will be included in the guideline narrative. |
| Foot and Ankle Subcommittee | Angela Jones presented procedures covered in the current guideline, which was written in 1992. Committee members were solicited for recommendations of physicians to sit on the subcommittee, and several MDs and Podiatrists were discussed. Dr. Chris Howe agreed to chair the subcommittee and Drs. Friedman and Harmon agreed to participate. Dr Howe and Dr Chamblin will approach the recommended foot specialists for potential participation. |
| Catastrophic Injury Project | Dr. Nicholas Reul presented the committee with an update on catastrophic care, and spoke to integration with other quality care measures and best practices. There are approximately 250 catastrophically injured workers per year in WA state. 8 % of claims account for 81% of the cost to L&I. Approximately 75% of that is high cost non-catastrophic claims, the most common being low back injury. The 3 overall goals and 5 point transformation plan was reviewed. L&I will establish a foundation of outcomes that relies on clinically meaningful measures of function. L&I was successful in allocating internal resources as demonstrated by dedicating nurse consultants and claims managers to catastrophically injured workers having 100% of catastrophic claims tracked and coordinated in the Occupational Health Management System. Current median time frame from date of injury to report of accident is 1 day.<br>The RFP for external nurse care managers was also completed; they are already being assigned to catastrophically injured workers; projecting 90% will be assigned by the end of February 2016.<br>The second portion of Dr. Reul's presentation involved a live demonstration of the catastrophic claims systems captured in the Occupational Health Management System (OHMS). The system demonstration showed how nurses and L&I staff can enter hospitalizations (even if claims not yet established), and track progress on claim acceptance, injured worker location and demographics, and assignment of resources. This significantly enhances communication and speeds decision making. |

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| | Dr. Carly Eckert presented on the retrospective evaluation component of the 5 point plan. She described the study aims including capturing the Injury Severity Score from the WA State Trauma Registry; A detailed description of this risk score was given. Increasing severity is associated with worse outcomes.<br><br>Question: what is the difference between a COHE and a catastrophic center of excellence? COHEs are designed to apply best practices early in the life of a claim, whereas centers of excellence have deeper resources and can deliver care for a longer term to selected groups of patients, such as catastrophically injured workers. Telehealth has the promise to facilitate quality care to more rural populations; this allows patients to stay within their community and local primary care providers can readily obtain expertise from specialists in larger, more distant centers. |
| Proposed Bylaw changes | Simone Javaher presented on proposed bylaw changes. Sections affected are G &T. Proposed changes were discussed. Section G changes are intended to clarify terms and nomination process and section T changes aim to clarify and streamline what notice and voting is required to adopt bylaw changes. Questions about having a quorum were raised, along with options for voting remotely and by proxy. Staff will incorporate the feedback into the current proposed changes. A vote is planned for the next IIMAC meeting on April 28. |
| PMP and EPIC integration | Hal Stockbridge shared information on a new option to integrate the Prescription Monitoring Program (PMP) into EPIC systems (electronic medical record system). |
| Opioid Update | The AMDG Opioid Guideline was endorsed by the Bree Collaborative, which will allow statewide implementation across multiple payers and health sectors. Short history of opioid addiction and the massive impact the drugs have on the country was explained. One major goal of the Bree opioid implementation workgroup is to reduce the numbers and duration of prescriptions of opioids written for those under the age of 20. The CDC guideline is moving forward with 12 new recommendations. The application of the opioid guideline issues to Top Tier best practices were discussed. Some concern was expressed over legacy cases and MDs being penalized. A 5% non-compliance threshold was reviewed for not escalating new starts. Suggestions given to make PMP queries a requirement for top tier providers. Concerns expressed about surgical patients not being able to receive NSAIDS and Tylenol in hospitals. |
| Lumbar Fusion | Dr. Gary Franklin gave an update on the Health Technology Clinical Committee (HTCC)'s new decision to not cover lumbar fusion for uncomplicated degenerative disk disease (UDDD). The updated lumbar fusion guideline was discussed, with the only changes being the removal of references to UDDD and Structured Intensive Multidisciplinary Program (SIMP). This means the guideline is returned to its previous version, prior to the addition of the SIMP language. No vote was needed. |
| Risk of Harm | Brook Martin, via phone, presented on the Risk of Harm analysis related to lumbar spine surgery – complications and reoperation rates. There has been an increase in lumbar surgeries in the age group over 65 and in the complexity of surgery. He presented his study design, including data from L&I. There has been significant analytic work and consultation with a subgroup of IIMAC to identify appropriate criteria, benchmarks and comparators, which the team believes is now fairly solid. Because of the low numbers of cases, it has been difficult to clearly identify significant outliers. Most individuals agreed that adding more years and potentially working with another payer (e.g. Medicaid) to get more cases would be beneficial. Concern was voiced about using the current data to take policy action (e.g. network action). L&I indicated that as with the opioids risk of harm analysis, the data alone will not be used to take action. Identifying patterns of poor care, case analysis and peer review will also be required. L&I plans to expand the analysis to increase the likelihood of accurately |

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| | identifying outliers. |
| Legislative Session Update | Leah Hole-Marshall updated the committee on 3 bills that directly affect L&I. Watching other bills as well. |
| Adjourn | Meeting was adjourned at 5:00. |